MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

02578

CERTIFICATE OF DEATH

Reg. Dist. No. 126

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: William J. Andrews

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife: Charlotte Galloway Andrews
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 6 1865

8. AGE:

Years	Months	Days	If less than one day
80	4	12	hrs. min.

9. Birthplace: Accomac Co. Virginia
(Town, county, and state)
10. Usual occupation: Ship Builder
11. Industry or business:

FATHER
12. Name: John Andrews
13. Birthplace: Accomac Co. Va

MOTHER
14. Maiden name: —
15. Birthplace: Accomac Co. Va

16. Informant: Mrs Winifred Rand
Address: Indian Head Md

17. Burial, cremation, or removal. Which?: Burial
Date thereof: Mch 21 46 (month) (day) (year)
Cemetery or crematory: Parkelay
Location: Parkelay Md Va

18. Funeral director: Chichester
Address: Washington D.C.

19. 3-18 1946 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 18 1946, at 2 44 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 14 1946 to Mch 18 1946 and that I last saw him alive on Mch 17 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Cardio-renal	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Bicknell M.D.
M. D. or other
Address: Marbury Md Date signed: Mch 18 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02579

Reg. Diat. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Mason Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Mason Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Henry Boswell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Bessie Lee Boswell

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1870

8. AGE:

Years	Months	Days	If less than one day
70	2	15	...hrs. ...min.

9. Birthplace: Pomonkey Charles Co. Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Tom. Boswell

13. Birthplace: Charles Co. Md.

MOTHER

14. Maiden name: Unknown.

15. Birthplace: Unknown.

16. Informant: Jos. Edward Boswell

Address: Marlboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 11 46 (month) (day) (year)

Cemetery or crematory: Bumpy Oak Cemetery

Location: Pomonkey Md.

18. Funeral director: Hunt & Ryon.

Address: Waldorf

19. March 9 1946 (Date rec'd by registrar) Mary Saunderland Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 8 1946 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17 1946 to Mch 8 1946 and that I last saw h... alive on Feb. 17 1946

Immediate cause of death	DURATION
Cardio-vascular disease	
Cerebral Apoplexy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. C. Bicknell MD

M. D. or other

Address: Marlboro Md Date signed: Mch 8 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02580

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Bel alton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Bel alton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Neale Hamilton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Mary Emily Hamilton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1867

8. AGE:

Years	Months	Days	If less than one day
78	6	17	hrs. min.

9. Birthplace: Chas. Co. Md.
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business
FATHER 12. Name: Francis P. Hamilton
13. Birthplace: Chas. Co. Md.
MOTHER 14. Maiden name: Priscilla Neale
15. Birthplace: Chas. Co. Md.
16. Informant: Mary H. Mullen
Address: Bel alton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/25/46 (month) (day) (year)
Cemetery or crematory: St. Ignatius
Location: Bel alton, Md
18. Funeral director: Hewett & Payne
Address: Waldorf, Md.
19. 3-23-46 (Date rec'd by registrar) 19 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1946, at 4 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to March 23 1946
and that I last saw h alive on 19
Immediate cause of death: Chronic Myocarditis — DURATION: 1 Yr
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ernest L Jenner M D.
M. D. or other
Address: Bel alton Md. Date signed 3-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

02581

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: SOPHIE S. HERBERT

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: C. Posey Herbert
6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): 1862-4-16

8. AGE: Years	Months	Days	If less than one day
83	10	20	hrs. min.

9. Birthplace: Charles Co. Md (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Benjamin Swann
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name: Sarah Odd
15. Birthplace: Charles Co. Md

16. Informant: C. Posey Herbert
Address: Hughesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-8-46 (month) (day) (year)
Cemetery or crematory: Old Fields Cemetry
Location: Hughesville, Md

18. Funeral director: Elmer M. Quade
Address: Hughesville, Md

19. 3-7 (Date rec'd by registrar) 1946 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1946 19 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 46 to 19; and that I last saw h. alive on March 6 19 46

Immediate cause of death	DURATION
Carcinoma of stomach	2 yrs. +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Dep. Medical Examiner
23. SIGNATURE: Jona L. MacKaraegh, M.D. M. D. or other
Address: La Plata, Md Date signed 3-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

CB 02582

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles

City or town Rural La Plata 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County

City or town Mc Laughlin Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. F. 225 - E. 3-4 Ave Loop, Vancouver

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Franklin Spitten

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of ~~husband~~ or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 20 - 85

8. AGE: Years	Months	Days	If less than one day
60	11	16	hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Henry Spitten

FATHER 13. Birthplace Newton N. J.

MOTHER 14. Maiden name Mira Kansbonger

MOTHER 15. Birthplace Troy Grove Ill

16. Informant Mrs ~~Franklin~~ J. E. Jessup.

Address La Plata, Md.

17. Removal Date thereof 3-7-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mrs. Vernon W. Heckinger

Location 7 225 - E. 3-4th Ave Loop Vancouver, Washington

18. Funeral director

Address Hunt & Ryon, Waldorf Md

19. 3-7-46 19 Julia H Passey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 6 - 1945, at 8 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-6 1945, to 3-6 1946

and that I last saw h.. alive on 3-6-46 19

Immediate cause of death	DURATION
Coronary Thrombosis	3-6-46
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Hedden M.D.

M. D. or other

Address La Plata Md Date signed 3-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

02583

Reg. Dist. No. 700

1. PLACE OF DEATH:
County: C. Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo.
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Constance Mudd

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband ~~or wife~~: William E. Mudd
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 6 1875

8. AGE: Years	Months	Days	If less than one day
70	5	22	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housekeeping
11. Industry or business:
FATHER 12. Name: John Francis Mudd
13. Birthplace: Md.
MOTHER 14. Maiden name: Imogene T. Miles
15. Birthplace: Md.
16. Informant: Mrs Alice Mudd
Address: Brandywine, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-4-46 (month) (day) (year)
Cemetery or crematory: St. Julias
Location: Clinton, Md.
18. Funeral director: Hewitt & Ryan
Address: Waldorf Md
19. 3-4 (Date rec'd by registrar) 1946 Julian H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-1 1946, at 5.06 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-6 1945, to 3-1 1946
and that I last saw h[illegible] alive on 3-1 1946.

Immediate cause of death	DURATION
Congestive Heart Failure	3-1-46
Due to: Hypertensive Heart Disease	9-6-45
Due to:	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: La Plata Md Date signed 3-1-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

02584

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: SARAH CAROLINE PARKER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Thomas Parker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7 1853

8. AGE:	Years	Months	Days	If less than one day
	92	11	15	hrs. min.

9. Birthplace: Chas. Co. Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: George Parker

FATHER 13. Birthplace: Chas. Co. Md.

MOTHER 14. Maiden name: Caroline Roach

MOTHER 15. Birthplace: Charles Co. Md

16. Informant: Jeanette House

Address: Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-25-46 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetry

Location: Bryantown, Md

18. Funeral director: Elmer M. Quade

Address: Hughesville, Md

19. 3-23-46 (Date rec'd by registrar) 19 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1946 at 3 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on March 22 1946, to — 19

and that I ~~last~~ saw h... alive on March 22 1946

Immediate cause of death	DURATION
Generalized arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Dep. Med. Examiner

23. SIGNATURE: James L. MacKavanagh, M.D.
M. D. or other

Address: Lilla, Md Date signed 3-23-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1258 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Faulkner

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Alma Swann

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Oscar Sutton

7. Birth date of deceased (mo., day, yr.): July 29 6.(c) If alive, give age — years

August 29, 1881

8. AGE: Years: 64 Months: 7 Days: 3 If less than one day: hrs. min.

9. Birthplace: St. Mary's Co. Md.

(Town, county, and state)

10. Usual occupation: Home

11. Industry or business: own home

FATHER 12. Name: William Burroughs

13. Birthplace: St Mary's Co Md

MOTHER 14. Maiden name: Anna Rebecca Burroughs

15. Birthplace: St Mary's Co Md

16. Informant: Mrs Robert Simpson

Address: La Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7 1946 (month) (day) (year)

Cemetery or crematory: Christ Episcopal Cemetery

Location: Chaptico St Mary's Co Md

16. Funeral director: Hunter & Taylor

Address: Mechanicsville Md

19. Mar 5 1946 (Date rec'd by registrar) M. L. Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 1946 at 12:46 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19 to 3-4- 1946

and that I last saw h alive on March 4, 1946

Immediate cause of death	DURATION
Congestive heart failure	2 wks
Due to Hypertensive heart disease	3-4 yrs.
Due to Chronic glomerulonephritis	8 yrs.+
Other conditions Chronic bronchitis	?
Chronic cholecystitis	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. MacKenzie, M.D. M. D. or other

Address: La Plata, Md. Date signed 3-4-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

02586

CERTIFICATE OF DEATH

★ Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Aubrey S. Willett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1905

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
41	2	17		

9. Birthplace: Chas. co. Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: Dudley N. Willett
13. Birthplace: Chas. co. Md.

MOTHER
14. Maiden name: Mary Elizabeth Posey
15. Birthplace: Chas. co. Md.

18. Informant: Mrs Louise Humphrey
Address: 2548, 14 St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/46 (month) (day) (year)
Cemetery or crematory: Congressional
Location: Washington D.C.
18. Funeral director: Hunter & Ryon
Address: Waldorf, Md

19. 3-25- 1946 (Date rec'd by registrar) Julia A. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1946, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19 to 3-23 1946 and that I last saw h(im) alive on Jan 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3-23-46
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Allen M.D. M.D. or other
Address: La Plata, Md Date signed: 3-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15